# WAYNE COUNTY FAMILY & CHILDREN FIRST COUNCIL
# INTRACOUNTY CONSENT TO OBTAIN & RELEASE INFORMATION

## CLIENT NAME _____ D.O.B. _____

**I give my permission for the following individuals and/or organizations through their designated representatives to exchange information regarding case history and treatment goals of the above named child in order to develop a Comprehensive Service Plan:**

School (District) _____
Mental Health & Recovery Board of Wayne & Holmes Cos.
Wayne County Board of DD
Wayne County Juvenile Court
Tri County Educational Service Center
Wooster City Schools
Wayne County Children Services Board
Parent Advocacy Connection
The Counseling Center of Wayne and Holmes Counties
Catholic Charities of Wayne County
HOME Choice Program - ODJFS
Other (Specify) _____

***The above individuals/organizations may be invited to Service Coordination after discussion and parental agreement. All may be involved if services are requested that require funding.***

**I UNDERSTAND THAT INFORMATION ABOUT ME AND MY CHILD, WHEN UNDER SUBPOENA, WILL BE REQUIRED TO BE RELEASED WITH OR WITHOUT MY SIGNED CONSENT:**
**PURPOSE OF NEED FOR DISCLOSURE:** This person is voluntarily participating in a comprehensive service program. All of the above person and/or agencies are involved in formulating and carrying out the treatment plan.

**SPECIFIC INFORMATION TO BE DISCLOSED**: Treatment plan, treatment goals, progress towards goals, history, test results (physical, psychiatric, psychological), medications, clinical impressions, obstacles to treatment, Comprehensive Reunification Plan, school/educational records, and: _____

**NOTE**: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I have read and fully understand the content of this form. If I do not read or understand English, this form has been read and fully explained to me in a language I can understand. I further understand that this information cannot be released to a third party or agency not named on this form. This consent to disclose may be revoked by me in writing at anytime except to the extent that action has been taken in reliance thereon. This release form expires in: **( MUST CHOOSE ONE OF THE FOLLOWING)**

**____ I will come in every *Ninety (90) days to sign a new release.**
*(*for Alcohol and Drug cases this Release of Information must be renewed every 90 days).*

**_____ I waive my right to require that this Release of Information be renewed every ninety (90) days. By waiving my right, I hereby permit this Release to remain in effect until I revoke it by signing below. I understand that this release will be reviewed on an annual basis.**

_____ / _____ _____
Signature of client/parent/authorized person Relationship Date

_____ / _____ _____
Signature of client/parent/authorized person Relationship Date

_____ _____
***Witness** Date

This consent revoked by: _____ on _____
(name) (date)

Rev. FEB 2017